Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE NORTH DALLAS
PO BOX 1210
FRISCO TX 75254

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative
Box Number 01

MFDR Tracking Number
M4-13- 2426-01

MFDR Date Received
May 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached date of service 8/6/12 was not paid in full. At the receipt of the preauthorization letter, we misunderstood, and thought that chiropractic therapy was approved. Therefore, we performed 98940 on the patient. It was brought to our attention that physical therapy was actually authorized. Since you already paid the chiropractic therapy in the amount of $41.22, we are asking that the amount be applied to code 97140, since that is the preauthorized service. We are not charging the chiropractic adjustment, and are correcting this error in our system. You have paid every other physical therapy charge under this preauthorization number. Please note, this patient had preauthorization, and PER RULE 134.600, the carrier shall not withdraw preauthorization once issued. Therefore these claims should be paid in full."

Amount in Dispute: $51.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached is the payment EOB for code 97140."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2012	97140	$51.84	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W3 – Additional payment made on appeal/reconsideration
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - U687 – This procedure is mutually exclusive to another on this date of service. By clinical practice standards, this procedure should not or cannot be performed in the same treatment period.

Issues

1. Did the requestor bill in conflict with the NCCI edits?
2. Did the insurance carrier issue payment for disputed CPT code 97140-GP?

Findings

1. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The Medical Fee Dispute Resolution section completed NCCI edits to help identify edit conflicts that would affect reimbursement. No NCCI edits conflicts were identified for the disputed CPT codes billed on August 6, 2012. As a result, the disputed services are reviewed pursuant to 28 Texas Administrative Code § 134.203 (c).
2. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title." Review of the submitted documentation finds that:

   The MAR for CPT code 97140 is $46.57 x 2 units = $93.14. Review of the EOB submitted by the requestor indicates that the insurance carrier issued payment in the amount of $41.22; the requestor seeks an additional payment in the amount of $51.84 for a total reimbursement of $93.06. Review of the EOB dated June 21, 2013 submitted by Liberty Mutual (check reference # 0026615889), supports that the insurance carrier issued payment in the amount of $93.06 for CPT code 97140-GP. The requestor seeks additional reimbursement in the amount of $51.84, therefore no additional reimbursement is recommended for CPT code 97140-GP.

   Review of the submitted documentation finds that the insurance carrier submitted sufficient documentation to support that payment was issued for the disputed CPT code 97140-GP, as a result no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		January 23, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).